No. 89-1044

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., ET AL.,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The First Circuit

BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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The American Dental Association respectfully submits this brief *amicus curiae* in support of the petition for a writ of certiorari filed by petitioner. This brief *amicus curiae* is filed with the written consent of all parties.

INTEREST OF AMICUS CURIAE

The American Dental Association ("ADA") is organized as a not-for-profit corporation under the laws of the State of Illinois. It is a voluntary professional association with

over 140,000 practicing member dentists, representing approximately 75% of this nation's dentists. The stated object of ADA is to encourage the improvement of the oral health of the public and to promote the art and science of dentistry.

The facts in this case specifically involve reimbursement of physicians for professional services. The key issues, however, concern the method by which all independent health care professionals in the United States can compete with dominant health care financing entities with respect to the marketing and reimbursement of their services. As is the case in medicine, and reflected in the facts of this case, many markets for the financing of dental care are dominated by one or two insurance companies or service benefit corporations, such as respondent, Blue Cross. These third parties thus wield tremendous monopoly power. However, at the provider level, and probably to a greater extent than medicine, the overwhelming number of dental practices consist of sole practitioners or groups of two or three. Thus, horizontally, the practice of dentistry reflects the historic free market concept.

The independent practice association ("IPA") is a vertical integration by health care providers to create a product of their health services which can be marketed to the health care financing entities, either the dominant fee-for-service insurance companies, such as Blue Cross, or health maintenance organizations ("HMOs"), which appear to be the primary alternative financing system.

The antitrust enforcement agencies have issued stringent guidelines as to the structure and conduct of the IPA, because it represents a combination of competitors. Antitrust enforcement experts have suggested that such organizations should constitute less than 35% of the providers in a geographic market area, that the providers

should undertake significant risk sharing, and that other efficiencies should be evident from the integration, such as utilization control or peer review. "Health Care and Antitrust Enforcement: The Buyer's Eye View," remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division (February 28, 1989); "Antitrust Enforcement and Health Care: Current Developments and Future Trends," remarks of Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division (November 4, 1989).

This close antitrust scrutiny of the IPA stands in stark contrast to the opinion of the Court of Appeals in this case with respect to permissible actions of a monopolistic health care financing entity. The appellate decision in effect establishes a *per se* rule of legality for any competitive reaction by a monopolist insurer if undertaken under the protection of a colorable business reason. If permitted to stand, this decision will hinder, or render impossible, emerging competition to the dominant insurance companies in the health care financing market, including dentistry. Such a development will filter down and foreclose opportunities for competition at the IPA level. ADA believes that this decision by the Court of Appeals was in error, and that if allowed to stand it will severely injure the competitive process in health care, including dentistry. It should be noted that ADA strenuously supports the traditional modes of third party reimbursement of providers that retain the concept of allowing patients to select the provider of their choice ("freedom of choice"). It is ironic, therefore, for ADA to support in this case the position of an alternative mode of health care delivery. The key issue which has compelled ADA to speak out in this instance is the apparent unfettered right of a traditional third party financing entity to engage in anticompetitive monopolistic behavior.

An effort has been made in the preparation of this brief *amicus curiae* to avoid a mere repetition of the arguments made by the petitioner and the other *amici curiae* in support of the petition. ADA is in substantial agreement with the arguments made in the brief *amicus curiae* filed by the American Medical Association.

SUMMARY OF ARGUMENT

Blue Cross should not be protected from the intended consequences of its actions in this case by the insurance exemption to the antitrust laws. The jury's verdict pronounced these actions to be the predatory activity of a monopolist. As such, they fall outside of the insurance exemption and, under existing and well reasoned precedent, constitute a violation of Section 2 of the Sherman Act.

ARGUMENT

A.

THE CONDUCT OF BLUE CROSS WAS THE PREDATORY ACTIVITY OF A MONOPOLIST.

Blue Cross has conceded that it has monopoly power in the health care insurance market in Rhode Island. Ocean State has acknowledged that Blue Cross has acquired these historical advantages legitimately. *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1110 (1st Cir. 1989). Whatever the historic reasons for the current monopoly position, it can be safely assumed that this

market advantage was not forged in the heat of competition. Nearly all Blues plans, as is the case with service benefit dental health insurance, were initiated by providers and substantially controlled by them to the point where they obtained their dominant market position.[1] While these dominant plans are no longer subject to provider control, they remain non-profit entities with limited incentive, other than competition, to introduce efficiencies with respect to their products or services.

The fact that these third parties were allowed to achieve such dominance in provider reimbursement while under the control of providers is something of an anomaly that can be explained only by a combination of two historical accidents. First, such power arose before this Court defined and narrowed the insurance exemption to the antitrust laws. *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Second, this market dominance developed before this Court's decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) and its progeny, through the recent decision in *F.T.C. v. Superior Court Trial Lawyers Ass'n*, ____ U.S. ____, 110 S. Ct. 768 (1990), generally applying the antitrust laws to the professions. In sum, there is no showing that Blue Cross's monopoly position in this case resulted from a superior product, business acumen or other economic efficiencies.

In this context, the antitrust laws should not favor the support or protection of monopoly status of an entity which achieved its dominant position in substantial part because

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[1] See *Bureau of Competition, FTC, Staff Report on Medical Participation and Control of Blue Shield and Certain Other Open-panel Medical Prepayment Plans*, April 1979 (unpublished).

it was not subject to the scrutiny of the antitrust laws. This argument is especially compelling absent any showing of market efficiencies resulting from the conduct of the monopolist.

Viewing the evidence most favorably to the petitioner, the actions of Blue Cross were:

- The establishment of HealthMate, an HMO look-alike to compete with Ocean State. It had no expectation that HealthMate would be profitable. Its main purpose was to slow or stop Ocean State's growth and seek to make Ocean State unprofitable.
- The establishment of a pricing differential on its principal product, fee-for-service health care financing coverage. This coverage was available at the lowest rate from Blue Cross if the purchaser took neither the Blue Cross HMO look-alike nor Ocean State. The cost increased if the purchaser took HealthMate. It increased further if Ocean State or another competitor's HMO were also offered.
- The introduction of a "Prudent Buyer" or "most favored nations" concept into its reimbursement of physicians, i.e., if a physician accepted a lower fee from Ocean State than that ordinarily paid by Blue Cross, Blue Cross also required the physician to take the lower fee from it rather than its ordinary payment.

Petitioner asserts that the evidentiary record shows the "Prudent Buyer" plan was imposed only against the physicians working for Ocean State. Petitioner further asserts that Blue Cross actually encouraged physicians to drop from Ocean State, thus raising Blue Cross's own costs, which amply demonstrates that the motivating purpose of this activity was not to economize but to punish Ocean State. Petitioner's Brief, at p. 21.

This activity certainly is of the type that the antitrust laws would address if carried out in combination by two independent entities, albeit with a total market share much less than that enjoyed by Blue Cross. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *National Macaroni Manufacturers Ass'n v. F.T.C.*, 345 F.2d 421 (7th Cir. 1965). Similarly, a monopolist, who has obtained monopoly power because of an exemption from the antitrust laws, should not be permitted to engage in such activity absent a showing of market efficiency.

The court in *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980) ("*Berkey Photo*") found the dominant market entity's conduct justified on the basis of the efficiencies inherent in innovative new products. Blue Cross's actions in seeking to raise costs to its rival Ocean State, sometimes at increased costs or loss of market share to Blue Cross, are not justified under the reasoning in *Berkey Photo*. To the contrary, if the ruling by the Court of Appeals is left undisturbed, the costs to the consumer will rise. Most medical and dental health plans which reimburse the provider on the basis of a usual and reasonable fee do not prohibit balance billing. Therefore, were the "most favored nations" pricing policy of Blue Cross in this case to become widespread, some of the amounts not reimbursed under such a pricing policy inevitably would be passed to the consumer in order to make up the difference between the lower amount reimbursed by the insurance company and the fee of the provider. The opinion of the Court of Appeals did not consider that consumers in an HMO achieve purported lower costs by giving up some things in return, such as an unlimited or free selection of the treating doctor. Blue Cross sought to impose its fee reductions (with the possibility of higher cost to the

non-HMO patient) on providers treating patients who were not willing to make this trade-off. In the words of *Berkey Photo*, this is conduct ". . . which a firm would have found substantially less effective, or even counterproductive, if it lacked market control." 603 F.2d at 291.

B.

THE McCARRAN-FERGUSON ACT DOES NOT SHIELD BLUE CROSS FROM ANTITRUST SCRUTINY AS TO ITS INTENTIONS.

Blue Cross should not be afforded immunity for its predatory actions under the McCarran-Ferguson Act, 15 U.S.C. Sections 1012(b), 1013(b) ("Act"). The Court of Appeals' application of this statute was in error for two reasons.

First, it was inappropriate to segregate Blue Cross's conduct with regard to the commencement, marketing and pricing of its HMO look-alike and consider these activities solely in the context of whether they constituted the business of insurance. Intention is a consideration in the analysis of whether a monopolist's activity constitutes prohibited predatory conduct. *Aspen Skiing Co. v. Aspen Highland Skiing Corp.*, 472 U.S. 585, 605 (1985) ("*Aspen Skiing*"). Thus, if the totality of Blue Cross's actions indicate an intention to exclude a competitor by methods not permitted to a monopolist, the fact that some of the activity arguably falls within the Act's exemption is of no import.

Second, in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221-22 (1979), this Court ruled that the primary purpose of the insurance exemption is to permit separate entities to share information on such subjects as rate setting and statistical matters to carry on the business of insurance more efficiently under the auspices of

state regulation. It cannot seriously be argued that Congress intended, or that the language of the Act provides, that the activities of a monopolist, designed primarily to intimidate and frustrate an emerging rival, rather than to bring efficiencies to the marketplace or the consumer, are protected under this Act.

The jury verdict in this case must be interpreted as a determination that Blue Cross's activity was primarily predatory. This predatory conduct should be more than sufficient to fall within the definition that, "(i)f a firm has been 'attempting to exclude rivals on some basis other than efficiency,' it is fair to characterize its behavior as predatory." *Aspen Skiing*, 472 U.S. at 605 (footnote omitted).

The Court of Appeals in this case has established a *per se* rule of legality for any self-interested conduct of a monopolist with a colorable business purpose. Such approval will not result in furthering constructive competition. What is required in this case is an economic analysis of the monopolist's activity, similar to a rule of reason approach. *Aspen Skiing Co. v. Aspen Highland Skiing Corp.*, 472 U.S. 585 (1985), *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980).

CONCLUSION

For all the foregoing reasons, the petition for certiorari should be granted.

Respectfully submitted,

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